

Town of Manchester, Connecticut
Supervisor's Report of Accident/Injury/Illness

Please complete **BOTH** sides of this form in pen for any work related accident/injury/illness and send the original to Jan Devendorf in Human Resources.

INJURED EMPLOYEE'S INFORMATION

Department: _____ Employee's Job Title: _____

Employee's Name: _____

Employee's Home Address: _____

City/State: _____ Zip: _____ Employee status: ft ____ pt ____

Employee's Telephone Number- Home: _____ Cell: _____

Gender: Male: ____ Female: ____ Date of Birth: _____ Date of Hire: _____

ACCIDENT/INJURY INFORMATION

Date of Occurrence: _____ Time of Occurrence: _____ a.m. ____ p.m. ____

What part of the employee workday? ____ performing normal work activities
____ entering or leaving work ____ working overtime ____ other (list) _____

Date Reported to Supervisor: _____ Time Reported to Supervisor: _____

Location (address) where accident/injury/exposure occurred: _____

Body part affected/injured: _____

Description of Accident/Injury: _____

Check one:

____ Incident only, no medical attention

____ Medical attention, no lost time

____ Medical attention and lost work time

Did employee refuse medical treatment? yes ____ no ____

If treatment was given away from worksite, where? _____

Witness to accident: _____

Witness statement: _____

OVER

Supervisor's Review of Incident

Please check any of the following which may have contributed to the accident/injury/illness. You may also write in more information on the "other" line:

<input type="checkbox"/> Improper lifting technique	<input type="checkbox"/> Improper maintenance	<input type="checkbox"/> Did not follow proper procedure
<input type="checkbox"/> Improper body mechanics	<input type="checkbox"/> Improper protective equipment	<input type="checkbox"/> Unsafe personal space/proximity to equipment
<input type="checkbox"/> Using equipment in unsafe way	<input type="checkbox"/> Unsafe equipment	<input type="checkbox"/> Working/walking on uneven surface
<input type="checkbox"/> Improper clothing	<input type="checkbox"/> Lack of training or skill	<input type="checkbox"/> Unsafe position
<input type="checkbox"/> Failure to use PPE	<input type="checkbox"/> Failure to follow instruction	<input type="checkbox"/> Failure to use seatbelt
<input type="checkbox"/> Operating at unsafe speed	<input type="checkbox"/> Operating without authority	<input type="checkbox"/> Other _____

Based on this incident is there a hazardous condition or unsafe process that should be addressed or corrected? yes _____ no _____

If yes, what steps will be taken to correct?

Please state what was discussed with employee to help prevent this type of accident/ injury from recurring:

Please indicate employee's comments or suggestions to prevent this incident from occurring again:

Did employee report the accident/injury/illness to a supervisor within 24 hours of occurrence?

Yes _____ No _____

My supervisor and I have reviewed and discussed the above accident/injury/illness.

Employee's signature

Date

I have reviewed the incident with my employee.

Supervisor's Name (print)

Supervisor's Signature

Telephone Number

Date

Reviewed by (Dept./Div. Head): _____ Date: _____
(Signature)

Called into CIRMA: _____ By: _____
Date Time Supervisor

1-800-OK-CIRMA (1-800-652-4762) Reference # _____